

## Memorandum

Date

FEB | 5 2002

From

Janet Rehnquist Inspector Genera

bject Improper Fiscal Year 2001 Medicare Fee-for-Service Payments (A-17-01-02002)

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Thomas Scully

To Administrator

Centers for Medicare and Medicaid Services

Attached, in accordance with our memorandum of understanding with the Centers for Medicare and Medicaid Services (CMS), is the final report on our review of Fiscal Year (FY) 2001 Medicare fee-for-service claims. The objective of this review was to estimate the extent of fee-for-service payments that did not comply with Medicare laws and regulations.

Based on our statistical sample, we estimate that improper Medicare benefit payments made during FY 2001 totaled \$12.1 billion, or about 6.3 percent of the \$191.8 billion in processed fee-for-service payments reported by CMS. These improper payments could range from reimbursement for services that were provided but inadequately documented to inadvertent mistakes to outright fraud and abuse.

We commend CMS for the continued reduction in the Medicare payment error rate; the current rate is less than half the 13.8 percent first developed for FY 1996. Our recommendations address the need to sustain this progress through provider training on maintaining adequate medical records and on properly coding claims.

We have incorporated CMS's comments on the draft report where appropriate. We appreciate the cooperation and assistance provided by you and your staff.

Because we consider this report an internal document, we plan no further distribution. If you have any questions, please contact me or have your staff contact Joseph E. Vengrin, Assistant Inspector General for Audit Operations and Financial Statement Activities, at (202) 619-1157.

Attachment

## Department of Health and Human Services

# OFFICE OF INSPECTOR GENERAL

# IMPROPER FISCAL YEAR 2001 MEDICARE FEE-FOR-SERVICE PAYMENTS



JANET REHNQUIST INSPECTOR GENERAL

FEBRUARY 2002 A-17-01-02002



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Inspector General

Subject

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This final report presents the results of our review of Fiscal Year (FY) 2001 Medicare feefor-service claims. The objective of this review was to estimate the extent of fee-for-service payments that did not comply with Medicare laws and regulations. This is the sixth year that the Office of Inspector General (OIG) has estimated these improper payments. As part of our analysis, we have profiled the last 6 years' results and identified specific trends where appropriate.

Our review of 6,594 claims valued at \$5.7 million disclosed that 954 did not comply with Medicare laws and regulations. Based on our statistical sample, we estimate that improper Medicare benefit payments made during FY 2001 totaled \$12.1 billion, or about 6.3 percent of the \$191.8 billion in processed fee-for-service payments reported by the Centers for Medicare and Medicaid Services (CMS). These improper payments, as in past years, could range from reimbursement for services provided but inadequately documented to inadvertent mistakes to outright fraud and abuse. The overwhelming majority (97 percent) of the improper payments were detected through medical record reviews which we coordinated. When these claims were submitted for payment to Medicare contractors, they contained no visible errors.

The FY 2001 estimate of improper payments is almost half the \$23.2 billion that we first estimated for FY 1996. As a rate of error, the current 6.3 percent estimate is the lowest to date, less than half the 13.8 percent reported for FY 1996. However, we cannot conclude that it is statistically different from the previous 3 years' estimates, which ranged from 6.8 to 8 percent. The decrease this year may be due to sampling variability; that is, selecting different claims with different dollar values and errors will inevitably produce a different estimate of improper payments.

We believe that since we developed the first error rate for FY 1996, CMS has demonstrated continued vigilance in monitoring the error rate and developing appropriate corrective action plans. For example, CMS has worked with provider groups, such as the American Medical Association and the American Hospital Association, to clarify reimbursement rules and to impress upon health care providers the importance of fully documenting services. Such efforts have contributed to the large reduction in the rate. In addition, due to efforts by CMS

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and the provider community, the overwhelming majority of health care providers follow Medicare reimbursement rules and bill correctly. In this regard, since FY 1998, over 90 percent of Medicare fee-for-service payments have contained no errors. Lastly, fraud and abuse initiatives on the part of CMS, the Congress, the Department of Justice (DOJ), and OIG have had a significant impact.

However, continued vigilance is needed to ensure that providers maintain adequate documentation supporting billed services, bill only for services that are medically necessary, and properly code claims. These problems have persisted for the past 6 years.

#### BACKGROUND

The Medicare program (Title XVIII of the Social Security Act) was established by the Social Security Amendments of 1965 to cover the health care needs of people aged 65 and over, the disabled, people with end stage renal disease, and certain others who elect to purchase Medicare coverage. In FY 2001, about 40 million beneficiaries were enrolled in the program, and CMS incurred about \$240 billion nationwide in Medicare benefit payments. Fee-for-service payments accounted for about \$191.8 billion of this total.

Medicare consists of two major programs, each with its own enrollment, coverage, and financing:

- C Hospital insurance, also known as Medicare Part A, is usually provided automatically to people aged 65 and over and to most disabled people. It covers services rendered by participating hospitals (including prospective payment system (PPS) hospitals), skilled nursing facilities, home health agencies, and hospice providers.
- C Supplementary medical insurance, also known as Medicare Part B, is available to nearly all people aged 65 and over and the disabled entitled to Part A. This optional insurance is subject to monthly premium payments by beneficiaries. Medicare Part B covers physician and outpatient care, laboratory tests, durable medical equipment, designated therapy services, and some other services not covered by Medicare Part A.

The CMS pays the following types of contractors to process fee-for-service claims:

- C Fiscal intermediaries (FI) process Part A payments for hospitals, skilled nursing facilities, home health agencies, rural health clinics, hospices, end stage renal disease facilities, and other institutional providers.
- C Carriers process Part B payments for physicians, clinical laboratories, freestanding ambulatory surgical centers, and other noninstitutional providers.

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C Durable medical equipment regional carriers (DMERC) process claims from suppliers of durable medical equipment, prosthetics, orthotics, and other supplies under Medicare Part B except those for items incident to physician services in rural health clinics or included in payments to such providers as hospitals, skilled nursing facilities, and home health agencies.

To ensure the quality of care provided to Medicare beneficiaries, CMS also contracts with peer review organizations (PRO) to conduct a wide variety of quality improvement programs. For example, PRO medical review personnel assess medical record documentation to determine whether the services rendered met professionally recognized standards of care and were medically necessary and appropriate.

#### **AUDIT OBJECTIVE**

Our primary objective was to determine whether Medicare fee-for-service benefit payments were made in accordance with the provisions of Title XVIII and implementing regulations in 42 Code of Federal Regulations (CFR). Specifically, we determined whether services were:

- C furnished by certified Medicare providers to eligible beneficiaries;
- C reimbursed by Medicare contractors in accordance with Medicare laws and regulations; and
- C medically necessary, accurately coded, and sufficiently documented in beneficiaries' medical records.

#### AUDIT SCOPE AND METHODOLOGY

Statistical Selection Method. To accomplish our objective, we used a multistage, stratified sample design. In the first stage, our sample frame consisted of 146 contractor quarters. Twelve contractor quarters were selected based on probability-proportional-to-size using Rao, Hartley, Cochran methodology. We used fourth quarter FY 1999 Medicare fee-for-service benefit payments and the first, second, and third quarters of FY 2000 as the selection weighting factors (size of each contractor quarter). The 12 contractor quarters included 9 contractors, of which 3 were FIs; 4 were both FIs and carriers; 1 was a carrier and a DMERC; and 1 was an FI, a carrier, and a DMERC.

The second stage of our sample design consisted of a random sample of 50 beneficiaries from each of the 12 contractor quarters sorted into 4 strata by total payments for services. The random sample of 600 beneficiaries produced 6,594 claims valued at \$5.7 million for review. To ensure the completeness of the claim data, we reconciled Medicare contractor claim data to the CMS 1522 Monthly Financial Reports for the 12 contractor quarters selected. The CMS used these reports in preparing the FY 2001 financial statements.

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The relative probability of selection for the contractor quarters and beneficiaries was incorporated into the overpayment estimate so that the estimate was not biased by a focus on the larger contractors and the beneficiaries with higher payments. The statistical software used to compute the estimate included the appropriate formulas for the relative probabilities of selection, which are referred to as "weights."

We used a variable appraisal program to estimate the dollar value of improper payments in the total population. The population represented \$191.8 billion in fee-for-service payments.

**Audit Procedures**. We reviewed all claims processed for payment for each selected beneficiary during the 3-month period. We contacted each provider in our sample by letter and requested copies of all medical records supporting services billed. In the event that we did not receive a response to our initial letter, we made numerous follow-up contacts by letter and, in most instances, by telephone calls. At selected providers, we also made onsite visits to collect requested documentation.

Medical review staff from CMS's Medicare contractors and PROs assessed the medical records to determine whether the services billed were reasonable, adequately documented, medically necessary, and coded in accordance with Medicare reimbursement rules and regulations. To make these determinations, the staff applied coverage guidelines, including the Medicare carrier and FI manuals. In the case of physician evaluation and management codes, the medical staff used the Current Procedural Terminology (CPT) Manual developed by the American Medical Association. We coordinated these medical reviews to ensure their consistency and accuracy.

Concurrent with the medical reviews, we made additional detailed claim reviews, focusing on past improper billing practices, to determine whether:

- C the contractor paid, recorded, and reported the claim correctly;
- C the beneficiary and the provider met all Medicare eligibility requirements;
- C the contractor did not make duplicate payments or payments for which another primary insurer should have been responsible (i.e., Medicare secondary payer); and
- C all services were subjected to applicable deductible and co-insurance amounts and were priced in accordance with Medicare payment regulations.

Building on this methodology, in FY 1998, CMS began developing a Medicare contractor-specific error rate program called Comprehensive Error Rate Testing (CERT). The CERT will establish, for the first time, baselines to measure each contractor's progress toward correctly processing and paying claims. The results will reflect the contractor's performance and will identify specific provider billing anomalies in the region. Contractors will then develop targeted

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corrective action plans to reduce payment errors through provider education, claim reviews, and other activities, and CMS will evaluate their rate of improvement. At CMS's request and concurrently with the Medicare contractors' and PROs' medical reviews, the contractor selected to administer the CERT program reviewed the medical records for 4 of the 12 contractor quarters in our FY 2001 sample. Thus, 19 percent of the claims in this year's sample were subjected to two separate, independent medical reviews. In addition, we reviewed the CMS corrective action plan addressing recommendations from our previous years' reports. We made this review in accordance with generally accepted government auditing standards.

#### **RESULTS OF REVIEW**

Through detailed medical and audit reviews of a statistical selection of 600 beneficiaries nationwide with 6,594 fee-for-service claims processed for payment during FYs 2000 and 2001, we found that 954 claims did not comply with Medicare laws and regulations. We refer to these instances of noncompliance as improper payments. The contractors have disallowed and already recovered many of the overpayments identified in our sample, consistent with their normal claim adjudication process.

It should be noted that in cases where there was no or insufficient documentation supporting Medicare claims (estimated at \$5.1 billion this year), medical reviewers could not reach a decision on whether the services were properly authorized and medically necessary. In several cases, it was quite clear that Medicare beneficiaries had, in fact, received services, but the physician's orders or documentation supporting the beneficiary's medical condition was missing. While these claims did not meet Medicare reimbursement rules regarding documentation, we cannot conclude that the services were not provided or were otherwise wasteful.

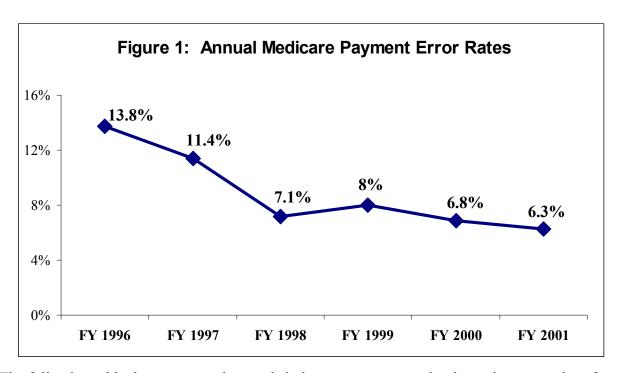
Based on our statistical sample, the point estimate of improper Medicare benefit payments made during FY 2001 was \$12.1 billion, or about 6.3 percent of the \$191.8 billion in processed feefor-service payments reported by CMS. The estimated range of the improper payments at the 95 percent confidence level is \$7.2 billion to \$16.9 billion, or about 4 percent to 9 percent, respectively.

Our historical analysis indicates that CMS has sustained its progress in reducing improper payments. For FY 1996, estimated improper payments totaled \$23.2 billion, or about 14 percent of the fee-for-service payments reported by CMS. Thus, we have seen the estimate drop by \$11.1 billion, a reduction of almost 50 percent, in 6 years. This reduction, in our opinion, is attributable to CMS's continuing corrective actions; efforts by health care providers to comply with Medicare reimbursement regulations; and fraud and abuse initiatives on the part of CMS, the Congress, DOJ, and OIG.

As noted in figure 1, this year's error rate is the lowest to date. While there is convincing evidence that it is statistically different from the FY 1996 estimate, we cannot conclude that it is statistically different from the estimates for the past 4 years. For example, the FY 2001

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\$12.1 billion point estimate falls within the FY 2000 estimated range of improper payments at the 95 percent confidence level (\$7.5 billion to \$16.2 billion). The slight decrease may be due to sampling variability, which means that this year's results could differ simply because selecting different claims with different dollar values will inevitably produce a different estimate of improper payments.



The following table demonstrates the trends in improper payments by the major categories of errors we have identified: (1) documentation errors, (2) medically unnecessary services, (3) coding errors, and (4) noncovered services and miscellaneous errors. Unsupported and medically unnecessary services have been pervasive problems, accounting for more than 79 percent of the total improper payments over the 6 years. It should be noted that CMS upheld over 90 percent of the overpayments identified in our FYs 1996-2000 samples and recovered the bulk of them. (The exceptions concerned cases under investigation.)

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| Type of Payment Error          | Fiscal Year |             |             |             |             |                     |
|--------------------------------|-------------|-------------|-------------|-------------|-------------|---------------------|
|                                | <u>1996</u> | <u>1997</u> | <u>1998</u> | <u>1999</u> | <u>2000</u> | <u>2001</u>         |
| Documentation errors           | 46.8%       | 44.3%       | 16.8%       | 40.4%       | 36.4%       | 42.9%               |
| Medically unnecessary services | 36.8%       | 36.9%       | 55.6%       | 32.8%       | 43.0%       | 43.2%               |
| Coding errors                  | 8.5%        | 14.7%       | 18.0%       | 15.8%       | 14.7%       | 17.0%               |
| Noncovered/other               | <u>7.9%</u> | 4.1%        | 9.6%        | 11.0%       | <u>5.9%</u> | (3.1%) <sup>1</sup> |
| Total                          | 100%        | 100%        | 100%        | 100%        | 100%        | 100%                |

Details on these error categories follow.

#### **Documentation Errors**

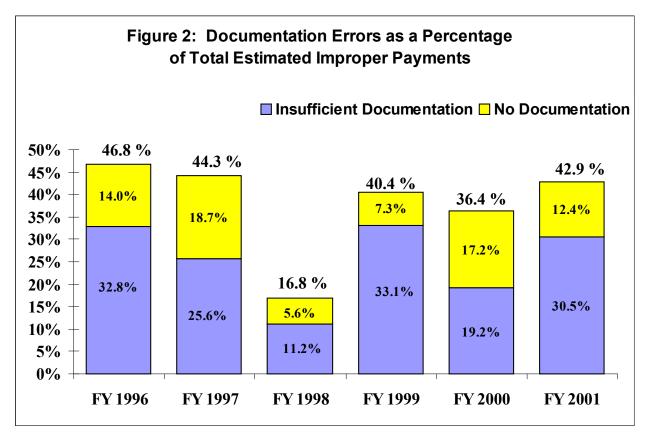
Documentation errors represented the largest error category in 3 of the last 6 years. For FY 2001, the dollar amount of these types of errors increased by almost 20 percent compared with FY 2000, and they remain a significant problem, accounting for an estimated \$5.1 billion in improper payments.

Documentation errors represented the largest error category in 3 of the last 6 years.

As illustrated in figure 2, the overall category of documentation errors includes two components: (1) insufficient documentation to determine the patient's overall condition, diagnosis, and extent of services performed and (2) no documentation to support the services provided. The dollar value of this year's errors in the "insufficient documentation" category increased by over 60 percent, while those in the "no documentation" category decreased by 27 percent since FY 2000.

<sup>&</sup>lt;sup>1</sup>The -3.1 percent applied primarily to "other" errors. In these cases, medical reviewers determined that the amounts billed should have been higher or that amounts previously denied were correct.

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Like other insurers, Medicare makes payments based on a standard claim form. Medicare regulation, 42 CFR 482.24(c), specifically requires providers to maintain records that contain sufficient documentation to justify diagnoses, admissions, treatments performed, and continued care. If sampled providers failed to provide documentation or submitted insufficient documentation, the contractors or OIG staff requested supporting medical records at least three times—and, in most instances, four or as many as five times—before determining that the payment was improper. Thus, for these errors, the medical review staff could not determine whether services billed were actually provided to the Medicare beneficiaries, the extent of services performed, or their medical necessity. In several cases, it was quite clear that beneficiaries had, in fact, received services, but the physician's orders or documentation supporting the beneficiary's medical condition was missing. While these claims did not meet Medicare reimbursement rules regarding documentation, we cannot conclude that the services were not provided or were otherwise wasteful.

Medical record documentation is required to record pertinent facts, findings, and observations about a patient's health, history (including past and present illnesses), examinations, tests, treatments, and outcomes. Medical records chronologically document the care of the patient and are an important element contributing to high-quality care. The records assist in:

C the evaluation and planning of the patient's immediate treatment and monitoring of the patient's health care over time by the physician and other health care professionals,

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- C communication and continuity of care among physicians and other health care professionals involved in the patient's care, and
- C appropriate utilization review and quality-of-care evaluation.

Some examples of documentation errors follow:

- *Physician.* A physician was paid \$84 for an office or other outpatient visit for the evaluation and management of an established patient. After several attempts to obtain the records supporting the visit, the physician's office acknowledged that the records did not exist for the date of service billed. As a result, the medical reviewers denied the \$84.
- *Physician.* A physician was paid \$52 for performing a spiral CT scan of a beneficiary's chest. After several attempts by the OIG and the medical reviewers to obtain the results of the scan, the physician acknowledged in writing that the beneficiary's medical records did not include test results. As a result, the medical reviewers denied the payment.
- *Physician.* A physician was paid \$189 for an end stage renal disease-related service. Medical reviewers found that there were no physician orders, progress notes, or consultations for the billed service. Therefore, the total payment was denied.
- Outpatient. An outpatient hospital was reimbursed \$189 for a series of 24 laboratory services. According to the medical reviewers, the results documented in the clinic notes demonstrated that 6 of the services had actually been performed, but no physician's orders, laboratory requisition, laboratory results, or other documentation was available to support the 18 remaining services. Therefore, \$175 of the payment was denied.
- Outpatient. An outpatient hospital was paid \$309 for a cardiovascular stress test with myocardial perfusion imaging. Although the services were rendered and the test results submitted, there were no physician orders for the procedures. Also, the medical records did not include documentation on the radio-pharmaceutical diagnostic imaging agent used. As a condition of payment, Medicare requires physician orders and documentation on the imaging agent used. As a result, the medical reviewers denied the \$309 as insufficiently documented.
- " **Outpatient.** An outpatient hospital was paid \$189 for six therapeutic radiation procedures, two of which were not documented in the medical records. Because the medical reviewers could not determine whether the two procedures had been provided, they denied \$63.

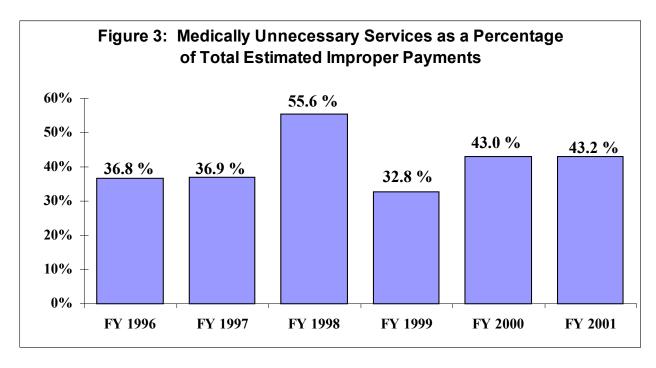
### **Medically Unnecessary Services**

This error category covers situations in which the medical review staff found enough documentation in the medical records to make an informed decision that the Medically unnecessary services accounted for at least a third of the improper payments each year.

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medical services or products received were not medically necessary. As in past years, the Medicare contractor or PRO medical staff made decisions on medical necessity using Medicare reimbursement rules and regulations. They followed their normal claim review procedures to determine whether the medical records supported the Medicare claims. Making such determinations has been an integral part of the Medicare contractors' quality control function since the program's inception, and OIG and CMS have relied on their expertise to perform these services for many years.

Medically unnecessary services, the largest error category this year, amounted to \$5.2 billion, of which 58 percent was attributable to inpatient PPS claims. As noted in figure 3, these errors represented a significant part of the overall error rate during the 6-year period.



Following are examples of medically unnecessary services:

- Inpatient PPS. A hospital was paid \$18,375 for inpatient care of a beneficiary admitted for malnutrition. The beneficiary, who had a history of cancer, chronic obstructive pulmonary disease, and alcohol abuse, was admitted to rehabilitation for strengthening exercises. According to the medical records, specifically the Interdisciplinary Discharge Summary, several goals were not met, including those for participation and endurance. The medical reviewers determined that the beneficiary was not a candidate for rehabilitation because there was no potential for long-term improvement. They determined that the beneficiary needed restorative, custodial nursing and/or hospice care and denied the total payment.
- " Inpatient PPS. A hospital was paid \$9,760 for psychiatric care of a beneficiary. Medical reviewers determined that an admission to an acute level of psychiatric care was not necessary; there was no indication of danger to self or others and no evidence of

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hallucinations or serious delusions. The reviewers determined that outpatient counseling and treatment would have been safe and effective for the patient. As a result, the payment was denied.

- Inpatient PPS. An inpatient acute care facility was reimbursed \$6,817 for a beneficiary admitted for a 6-day stay after being seen in the emergency room for lower back pain. According to the medical reviewers, however, the medical records indicated that the patient had a history of chronic lower back pain. In addition, the admission report showed that an MRI taken on the date of admission was negative for spinal cord compression, and the admitting physician stated that no further workup was needed at that time. Therefore, the medical reviewers determined that while the services rendered (evaluation and treatment for pain) were medically necessary, they could have been provided in an outpatient setting. As a result, the total amount was denied.
- *Inpatient PPS.* A hospital was paid \$4,046 for treating a beneficiary with dehydration who was transferred from a skilled nursing facility. During the 4-day stay, the patient was given IV fluids and evaluated by neurology and psychiatry. The medical reviewers concluded that the treatments could have been safely administered without acute hospitalization and that no treatments justified hospitalization. The total payment was denied.

### **Coding Errors**

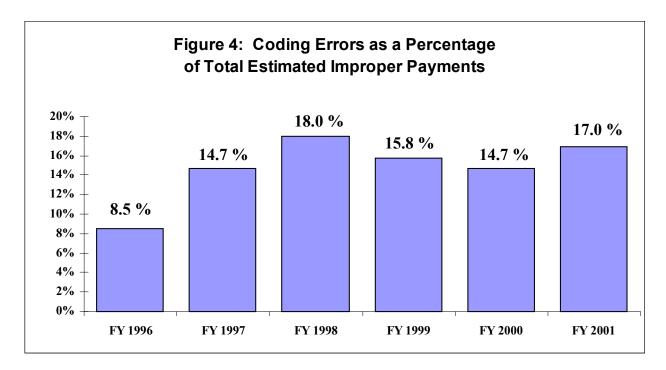
The medical industry uses a standard coding system to bill Medicare for services provided. For most of the coding errors found, the medical

Over the last 6 years, net estimated coding errors have remained consistently in the \$2 billion to \$3 billion range.

reviewers determined that the documentation submitted by providers supported a lower reimbursement code. However, we did find a few instances of downcoding which were offset against identified upcoding situations.

Over the last 6 years, the estimated dollar amount of coding errors (the net of upcoding and downcoding) has remained consistently in the \$2 billion to \$3 billion range. This year, incorrect coding is the third highest error category, representing \$2 billion, or 17 percent, of the total estimated improper payments. (See figure 4.) Physician and inpatient PPS claims accounted for over 90 percent of the coding errors over the 6 years reviewed.

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By letter dated June 1, 2000, the CMS Administrator notified Medicare physicians that CPT codes 99233 and 99214 for evaluation and management services had accounted for a significant portion of the FYs 1998 and 1999 coding errors. The Administrator noted that documentation for many of these services more appropriately supported CPT codes 99212 and 99231, respectively. The letter asked that providers, when billing for CPT code 99214, document at least two of the three key components: a detailed history, and/or a detailed examination, and/or medical decision-making of moderate complexity. This year's analysis showed continued problems with these same procedure codes:

CPT code 99233, subsequent hospital care. The physician should typically spend 35 minutes with the patient and perform at least two of these key procedures: a detailed interval patient history, a detailed examination, or medical decision-making of high complexity. Medical reviews of 338 services in FY 2001 disclosed that 142, or 42 percent, were in error. Of the 142 errors, 129 were incorrectly coded and subsequently downcoded to lower valued procedure codes. Most of the remaining errors were related to documentation problems. As noted in the table below, our analysis for all 6 years indicates significant payment errors for this procedure code.

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| Fiscal Year | Number of Number of Services Services Questioned |     | Percent of<br>Services in<br>Error |
|-------------|--------------------------------------------------|-----|------------------------------------|
| 1996        | 217                                              | 115 | Enoi                               |
| 1997        | 416                                              | 128 | 30.8%                              |
| 1998        | 457                                              | 114 |                                    |
| 1999        | 187                                              | 102 | 54.6%                              |
| 2000        | 449                                              | 220 |                                    |
| 2001        | 338                                              | 142 | 42.0%                              |

CPT code 99214, office or other outpatient visit. The physician should typically spend 25 minutes face-to-face with the patient and perform at least two of the following procedures: a detailed patient history, a detailed examination, or medical decision-making of moderate complexity. Medical reviews of 214 services disclosed that 67 were in error, of which 64 were incorrectly coded. The remaining errors related primarily to documentation. Again, we found consistent, significant errors for this code over the years:

| <b>CPT Code 99214</b> |                                   |                                     |                                    |  |  |
|-----------------------|-----------------------------------|-------------------------------------|------------------------------------|--|--|
| Fiscal Year           | Number of<br>Services<br>Reviewed | Number of<br>Services<br>Questioned | Percent of<br>Services in<br>Error |  |  |
| 1996                  | 140                               | 54                                  | 38.6%                              |  |  |
| 1997                  | 234                               | 86                                  | 36.8%                              |  |  |
| 1998                  | 168                               | 63                                  | 37.5%                              |  |  |
| 1999                  | 143                               | 81                                  | 56.6%                              |  |  |
| 2000                  | 191                               | 71                                  | 37.2%                              |  |  |
| 2001                  | 214                               | 67                                  | 31.3%                              |  |  |

In addition, although not highlighted in the Administrator's letter, we noted a high incidence of error in CPT code 99232, subsequent hospital care, in all previous years, with a substantial decline noted for FY 2001. The physician should typically spend 25 minutes at bedside with the patient and should perform at least two of the following key procedures: an expanded problem-focused interval patient history, an expanded problem-focused examination, or medical decision-making of moderate complexity. As illustrated in the next table, for FY 2001, medical reviews

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of 964 services disclosed that 146, or 15 percent, were in error. The majority, 109, were incorrectly coded, and the medical records consistently supported lower valued procedure codes. Most of the remaining errors were related to documentation problems.

| <b>CPT Code 99232</b> |                                   |                                     |                                    |  |  |
|-----------------------|-----------------------------------|-------------------------------------|------------------------------------|--|--|
| Fiscal Year           | Number of<br>Services<br>Reviewed | Number of<br>Services<br>Questioned | Percent of<br>Services in<br>Error |  |  |
| 1996                  | 597                               | 266                                 | 44.6%                              |  |  |
| 1997                  | 1,159                             | 350                                 | 30.2%                              |  |  |
| 1998                  | 911                               | 181                                 | 19.9%                              |  |  |
| 1999                  | 837                               | 279                                 | 33.3%                              |  |  |
| 2000                  | 881                               | 270                                 | 30.6%                              |  |  |
| 2001                  | 964                               | 146                                 | 15.1%                              |  |  |

Some examples of incorrect coding follow:

- *Physician.* A physician was paid \$158 for an office visit for the evaluation and management of a new beneficiary. This level of care requires a comprehensive history, a comprehensive examination, and medical decision-making of high complexity. The medical reviewers determined that the medical records supported a level of care that was less complex and two levels lower than that billed. Therefore, \$76 was denied.
- *Physician.* A physician was paid \$180 for an office consultation of a new patient. This level of care requires a comprehensive history, a comprehensive examination, and medical decision-making of high complexity. The medical reviewers determined that the physician performed a comprehensive history but only an expanded, problem-focused examination of 10 of the 18 body systems required for this level of care. As a result, the reviewers concluded that the care provided was three levels lower than that billed. Therefore, \$106 was denied.
- *Physician*. A physician was paid \$957 for five hospital visits requiring decision-making of high complexity, management of life- threatening conditions, and at least 30 minutes of care. However, the medical records indicated that the patient was stable, rather than in critical condition. The medical reviewers also noted that the records supported only decision-making of moderate complexity with an expanded, problem-focused examination and history. As a result, \$697 was denied.
- " *Physician.* A physician was paid \$90 for an office visit for the evaluation and management of an established patient. This level of care requires at least two of the three

key components: a comprehensive history, a comprehensive examination, and medical decision-making of high complexity. The medical reviewers determined that the physician performed only a detailed history and an expanded, problem-focused examination of only 8 of 18 body systems and made a medical decision of low complexity. As a result, they concluded that the level of care actually provided was one level lower than that billed and denied \$29 of the payment.

*Inpatient PPS.* A hospital was paid \$5,372 for an inpatient stay based on the principal diagnosis of a second-degree burn on the upper arm. The medical reviewers concluded that the burn appeared to be relatively minor and that the primary diagnosis code should have been related to a crush injury, a lower level diagnosis-related group (DRG). As a result, \$2,965 was denied.

#### **Noncovered Services and Other Errors**

Errors due to noncovered services have consistently constituted the smallest error category. Noncovered services are defined as those that Medicare will not reimburse because the services do not meet Medicare reimbursement rules and regulations. According to the *Medicare Handbook*, the following services are not covered by Medicare Part B:

- C most routine physical examinations and tests directly related to such examinations;
- C eye and ear examinations to prescribe or to fit glasses or hearing aids;
- C most prescription drugs:
- C most routine foot care; and
- C chiropractic services, unless the services are for the manipulation of the spine to correct a subluxation demonstrated by x-ray or by physical examination.

Following is an example of noncovered services identified during our review:

*Physician.* A physician was paid \$28 for an inpatient visit for the evaluation and management of a patient. The physician also billed for a discharge on the same day. Medicare guidelines state that a physician may not bill for more than one visit on the same day. As a result, the medical reviewers allowed the discharge payment but denied the inpatient visit as a noncovered service.

#### CONCLUSIONS AND RECOMMENDATIONS

Based on our FY 2001 sample, we estimate that the Medicare fee-for-service payment error rate is 6.3 percent, or \$12.1 billion. This dollar amount is slightly higher than that for FY 2000 due to an increase in Medicare expenditures; however, the error rate is the lowest to date. As in past

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years, these improper payments could range from reimbursement for services provided but inadequately documented to inadvertent mistakes to outright fraud and abuse.

The large reduction in improper payments since FY 1996, we believe, demonstrates CMS's vigilance in monitoring the error rate and developing appropriate corrective action plans. In addition, significant contributions have been made by provider organizations, such as the American Medical Association and the American Hospital Association, in clarifying reimbursement rules and in impressing upon their membership the importance of fully documenting services. Lastly, fraud and abuse initiatives on the part of CMS, the Congress, DOJ, and OIG have had a significant impact. All of these efforts have contributed to reducing the error rate by more than half from FY 1996 to FY 2001.

It is commendable that the overwhelming majority of health care providers follow Medicare reimbursement rules and bill correctly. In this regard, over 90 percent of the Medicare fee-for-service payments for FYs 1998, 1999, and 2000 and almost 94 percent of the payments for FY 2001 contained no errors. Thus, the majority of health care providers submit claims to Medicare for services that are medically necessary, billed correctly, and documented properly.

While our 6-year analysis indicates progress in reducing improper payments, it also shows that undocumented services and medically unnecessary services have been and continue to be pervasive problems. These two error categories accounted for more than 79 percent of the total improper payments over the 6 years. The CMS needs to increase its efforts to maintain progress in reducing these improper payments. In particular, CMS needs to increase its work with providers to ensure that medical records support billed services. These records not only assist providers in evaluating and planning the patient's treatment but also ensure continuity of care in the event that another caregiver must assume responsibility for the patient's care. In addition, medical records help to ensure the correct and timely processing and payment of provider claims.

#### We recommend that CMS:

- increase efforts to direct that the Medicare contractors expand provider training to further emphasize the need to maintain medical records containing sufficient documentation, as well as to use proper procedure codes when billing Medicare for services provided;
- continue to refine Medicare regulations and guidelines to provide the best possible assurance that medical procedures and services are correctly coded and sufficiently documented; and
- ensure that contractors recover the improper payments identified in our review.